Oskaloosa Chiropractic Clinic

Pediatric Patient Questionnaire

1. CONFIDENTIAL PATIENT INFORMATION:

Childs Name: _____ Date of Birth: _____ Gender: _____

Parent/Guardian Name: _____

Street Address: _____ Apt./Unit#: _____ City: _____ State: _____

Zip Code: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Height: _____ Weight: _____

Who is your primary physician? _____

2. How did you hear about us?

_____

3. Is your child receiving care from any other health professionals?
   - Yes
   - No

4. If yes, please name them and their specialty:

	Name	Specialty
1		
2		
3		

Others:

5. Please list any drugs/medications/vitamins/herbs/other that your child is taking:

	Medication Name	Dosage	Frequency	Reason for Taking
1				
2				
3				

Others:

CURRENT HEALTH CONDITIONS

6. What are the primary health concerns for your child?

7. Please describe when your child's issues first began and how they've progressed since:

8. What makes things better?

9. What makes things worse?

_____

HEALTH GOALS FOR YOUR CHILD

10. What are your top three health goals for your child:

1.

_____

_____

2.

_____

_____

3.

_____

_____

11. What would you like to gain from chiropractic care?

- ○ Resolve existing condition
- ○ Overall wellness + prevention
- ○ Both

12. Have you ever visited a chiropractor?

- ○ Yes
- ○ No

If yes, what is their name:

_____

13. What is their specialty?

- ○ Pain Relief
- ○ Physical Therapy & Rehab
- ○ Nutritional
- ○ Subluxation-based
- ○ Other

If other, specify:

_____

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy.

14. Any fertility challenges?

- ○ Yes
- ○ No

15. If yes, please explain:

16. Did mother smoke?

- Yes
- No

If yes, how many per week?

17. Did mother drink?

- Yes
- No

If yes, how many per week?

18. Did mother exercise?

- Yes
- No

19. If yes, please explain:

20. Was mother ill?

- Yes
- No

21. If yes, please explain:

22. Any ultrasounds?

- Yes
- No

23. If yes, please explain:

24. Please explain any notable episodes of emotional or physical stress during your pregnancy:

25. Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

26. Child's birth was:

○ Vaginal Birth ○ Scheduled C-section ○ Emergency C-section

At how many week's was your child born?

27. Child's birth was:

○ At home
○ At a hospital
○ At a birthing center
○ Other

If other, specify:

28. Birth Provider's Name:

29. Please check any applicable interventions or complications:

☐ Breech
☐ Manual assistance
☐ Vacuum extraction
☐ None of the above
☐ Induction
☐ Epidural
☐ Forceps
☐ Pain meds
☐ Episiotomy
☐ Cord-wrapped

If other, specify:

30. Please describe any other concerns or notable remarks about your child's labor and/or delivery.

31. Child's birth weight: _____ Child's birth height: _____ APGAR score at birth: _____ APGAR score at 5 minutes: _____

GROWTH & DEVELOPMENT HISTORY

32. Is/was your child breastfed?

- ○ Yes
- ○ No

If yes, how long?

_____

33. Difficulty with breastfeeding?

- ○ Yes
- ○ No

If yes, is there a certain side that is more difficult for them?

_____

34. Did they ever use formula?

- ○ Yes
- ○ No

35. If yes:

At what age:

_____

36. Did/does your child ever suffer from colic, reflux, skin issues, or constipation as an infant?

- ○ Yes
- ○ No

37. If yes, please explain:

38. Did/does your child frequently arch their neck/back, feel stiff, or bang their head?

- ○ Yes
- ○ No

39. If yes, please explain:

_____

_____

_____

_____

40. At what age did the child:

	Age
Respond to sound:	
Follow an object:	
Hold their head up:	
Vocalize:	
Teething:	
Sit alone:	
Crawl:	
Walk:	
Begin cow's milk:	
Begin solid foods:	

41. Please list any food intolerance or allergies, and when they began:

	Food intolerance / Allergy	When they began
1		
2		
3		

42. Please list your child's hospitalization and surgical history, including the year:

	Hospitalization / Surgery	Year
1		
2		
3		

43. Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

	Injury	Year
1		
2		
3		

44. Have you chosen to vaccinate your child?

- ○ No
- ○ Yes, on a delayed or selective schedule
- ○ Yes, on schedule

45. If yes, please list any vaccination reactions:

_____

_____

_____

_____

46. Has your child received any antibiotics?

- ○ Yes
- ○ No

47. If yes, how many times and list reason:

_____

_____

_____

_____

48. Any difficulty with bonding or social development?

- ○ Yes
- ○ No

49. If yes, please explain:

_____

_____

_____

_____

50. Night terrors or difficulty sleeping?

- ○ Yes
- ○ No

51. If yes, please explain:

52. Behavioral, social or emotional issues?

- ○ Yes
- ○ No

53. If yes, please explain:

54. How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

55. How would you describe your child's diet?

- ○ Mostly whole, organic foods
- ○ Pretty average
- ○ High amount of processed foods

56. Are there other health concerns, or is there anything else you'd like us to know about your child?

Patient Review of Systems

The nervous system controls and coordinates all organs and structures of the human body.

Please check the corresponding boxes for each symptom or condition you have experienced - including both past and present.

57.

	Past	Present
Colic & Excessive Crying		
Difficulty Latching / Nursing		
Reflux & Excessive Spit Up		
Projectile Vomiting		

Frequent Stiffening, Rigidity, Arching		
Difficulty Sleeping		
Torticollis		
Plagiocephaly		
Motor Milestone Delays		
Low Tone & Coordination Challenges		
Speech & Communication Delays		
Sensory Processing Challenges		
Social / Emotional Challenges		
Frequent Tantrums & Meltdowns		
Behavior Issues		
Hyperactivity & Impulsivity		
Anxiety & Emotional Instability		
ADHD / ADD		
Balance & Coordination Issues		
Visual & Auditory Processing Challenges		
Handwriting & Fine Motor Challenges		
Low Energy and Fatigue		
Depression & Lack of Confidence		
Lightheadedness & Dizziness		
Frequent Naseau & Malaise		
Headaches & Migraines		
Stick Neck & Shoulders		
Jaw, Swallowing, Sensory Food Aversions		
Vision & Hearing Issues		
Ear & Sinus Infections		
Sore Throat and Strep		
Swollen Tonsiles & Adenoids		
Strep & Upper Respiratory Infections		
Allergies and Autoimmune Challenges		
Chronic Inflammation		
Poor Metabolism & Weight Control		
Chronic Chest Colds & Cough		
Bronchitis & Pneumonia		

Asthma		
Blood Sugar Problems		
Skin Conditions / Rash		
Ulcerative Colitis, Crohn's, IBS		
Kidney Challenges		
Gas Pain & Bloating		
Gluten & Casein Intolerance		
Constipation		
Bladder & Urination Issues		
Hormonal Challenges		
Low Back Pain & Stiffness		
Lumbopelvic / SI Joint Pain		
Tight Hamstrings & Calves		
Toe Walking		
Poor Circulation & Cold Feet		
Weak Ankles & Arches		

ACKNOWLEDGEMENT & CONSENT

Patient or Parent/Guardian

_____ _____

Signature Date